Bureau of Health Care Quality and Compliance

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
					С			
NVS4009AGC			B. WING		12/07/2010			
OVIDER OR SUPPLIER			, ,	•				
HOME OF FAITH AND HAPPINESS		6418 SPRING MEADOW DRIVE LAS VEGAS, NV 89103						
· ·			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	(X5) COMPLETE DATE			
0 Initial Comments			Y 000					
The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 12/7/10. The grading re-survey was conducted for the 1/26/10 and 6/15/10 surveys. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of A.  The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, Category I residents. The census at the time of the survey was three. Three resident files were reviewed and four employee files were reviewed.  The following deficiencies were identified:		Y 532						
facility shall:  (g) Post, in a common calendar of activities residents of the major the facility. The caler (1) Prepared at least (2) Kept on	n area of the facility, a for each month that not r activities that will occu ndar must be: east a month in advanc file at the facility for no	ur in ee.						
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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

PRINTED: 03/18/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		( ) == = = =			(X3) DATE SURVEY COMPLETED C				
		NVS4009AGC		B. WING			07/2010		
NAME OF PROVIDER OR SUPPLIER  STE  HOME OF FAITH AND HAPPINESS  64			6418 SPRIN	REET ADDRESS, CITY, STATE, ZIP CODE 118 SPRING MEADOW DRIVE AS VEGAS, NV 89103					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FUL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X:  COMP  DA'  DA'  DA'  DEFICIENCY)				
Y 532	2 Continued From page 1			Y 532					
	Based on observation failed to post a mont activities for December This is a repeat deficient annual State Licensus Severity: 1 Scope	ciency from the 6/15/10 ure survey.	,						
Y 859 SS=E	449.274(5) Periodic resident	Physical examination of	a	Y 859					
	NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.								
	Based on record rev		ity						